SMALL WORLD PEDIATRICS

PATIENT DISCLOSURES

Patient Name:_____ DOB:_____

If Small World Pediatrics needs to contact me, I wish to be contacted in the following manner:

For follow up, medications, referrals or test results: (check all that apply)

___ Home Telephone listed on Information Sheet
- ___ OK to leave message with detailed information
- ___ Leave message with call back number only

___ Cell Phone on Information Sheet
- ___ OK to leave message with detailed information
- ___ Leave message with call back number only

___ Work Phone on Information Sheet
- ___ OK to leave message with detailed information
- ___ Leave message with call back number only

___ Written Communication on Information Sheet
- ___ OK to mail to my home address
- ___ OK to mail to my work/office
- ___ OK to fax _____

___ Other _____

For appointment confirmations, insurance and billing questions: (check all that apply)

___ Home Telephone listed on Information Sheet
- ___ OK to leave message with detailed information
- ___ Leave message with call back number only

___ Cell Phone on Information Sheet
- ___ OK to leave message with detailed information
- ___ Leave message with call back number only

___ Work Phone on Information Sheet
- ___ OK to leave message with detailed information
- ___ Leave message with call back number only

___ Written Communication on Information Sheet
- ___ OK to mail to my home address
- ___ OK to mail to my work/office
- ___ OK to fax _____

___ Other _____

_____ _____

Signature of Parent or Legal Guardian Date